Wyoming Healthcare Commission
April 25, 2005
Gillette, Wyoming
Minutes

Attendance

T. Chris Muirhead, Chairman, Steve Mossbrook, Vice Chair, George Bryce, Marlene Ethier, Jack Glode, M.D., Carol Jenkins, Dixie Roberts, Commissioners, Ken Vines, Insurance Commissioner, Ex-Officio, Anne Ladd, Executive Director, Emily Genoff, Assistant Director.

Introductions

Chairman Muirhead opened the meeting.

Presentations

<u>Pennsylvania Healthcare Cost Containment Council (www.PHC4.org) Executive Director Marc Volavka presented his organization's work to improve the quality and cost of healthcare in his state.</u>

He said the council was formed by a unique coalition of business and labor interests who were extraordinarily concerned about rising healthcare costs in the early 1980s. Pennsylvania was in an economic downturn and losing manufacturing – steel and chemical – and was one of the most unionized states in the country, with strikes going on about healthcare benefits, and paying for and cutting healthcare benefits. As a result, between 1984 and 1986, the business and labor communities voluntarily got together with insurance, business and physician communities to put together a database to look at what they were paying for and what kind of quality they were getting. Better quality costs less, Mr. Volavka said.

The 25-member Council now operates with a $4.1 million general fund appropriation and another $750,000 in data sale revenue. Appointed by the Legislature and Governor, the Council members are selected from lists of nominees proffered by the industries and organizations included in the Council's enabling legislation. The Council is an independent state agency that is purchaser driven and employs 60 people in four departments working on administration and finance, health policy, data collection and analysis, and communications. Mr. Volavka has to submit his budget for Governor's and legislative review, and must defend it. Since he became ED in 1998, the Council has received what it has asked for or more than what it has asked for every year a budget is submitted. He believes that is a measure of the value of the Council's work. The Council measures itself by web hits and its customers (number of purchasers of data, which has grown 100-fold since the Council's initiation). Customers fall into four broad categories: commercial clients (national consultants, Milliman and Robertson accounting firms), the provider community (hospitals and physician groups), researchers from all across the

country (academic and teaching institutions, think tanks) and state agencies (state agencies receive data at no cost – I made a decision when becoming director that it was imprudent to ask a sister state agency to pay and we now have data sharing arrangements). "I personally measure success when I get a phone call from a CEO or Chief Medical Officer saying can you come down and help us."

The Council's strategy to contain costs is to stimulate competition in the health care by giving comparative information about the most efficient and effective health care providers to individual consumers and group purchasers of health services; and giving information to health care providers that they can use to identify opportunities to contain costs and improve the quality of care they deliver. By statute, the Council is assigned three tasks: to collect, analyze and make available to the public data about the cost and quality of health care in Pennsylvania; to study, upon request, the issue of access to care for those Pennsylvanians who are uninsured; to review and make recommendations about proposed or existing mandated health insurance benefits upon request of the legislative or executive branches of the Commonwealth

Volavka advised the state of Wyoming not to let the perfect be the enemy of the good, when bringing together coalitions with a stake in the data. The PHC4 looks at the overall health of the hospital community in Pennsylvania and evaluates the care delivered to members of Health Management Organizations (HMOs). He provided examples of how the Council's reports have impacted the delivery and quality of care, including reducing the number of C-Section births. In January 2004, Pennsylvania was the first state in the country to collect data on hospital acquired infections. With one full year of data now available, it is possible to determine the cost to the state of hospital-acquired infections ($125 million in state funds, $1 billion statewide). This was especially significant when it became clear to the Governor's Budget Office that the state's Department of Welfare and Medicaid would be more than a billion dollars in the red. Not all hospitals are reporting. Statute requires hospitals to report their data or be fined, but the statute is not enforced. Rural hospitals are included in the dataset and are encouraged to participate. In 1996, a significant majority of the hospitals were in compliance, shifting the pressure from the Council's responsibility to industry self-regulation.

Initial public reports were printed. Because there was so much data involved the printed reports were regional and enormous and pertained only to larger hospitals. Now there is an interactive online database that is public and allows the user to do some data sorting and analysis. Hospital and HMO financial and clinical data is facility specific and risk adjusted to equalize patients and level of sickness on admission to the hospital before quality rating is imposed. Ratings are based on outcomes (including mortality rates for cardiac care). Only five cases per hospital are required for the model PHC4 is using to work; abnormal patterns in outcomes become visible very quickly per procedure. Hospitals of all sizes are included in the database.

The Council has gotten a reputation for being the "gold standard" and while the data is not perfect, it has become the comparator in Pennsylvania. Data is cross checked. Over the course of 15 years, a back and forth editing system has been developed with

MediQual (PHC4's partners in clinical data collection) and internally. Pennsylvania has 182 hospitals; about 50 hospitals now have a zero error rate in reporting. Processing is not held up if a hospital is incomplete in its reporting but a hospital may be missing from a public report. Routine audits are conducted. Data is due 90 days after the close of a quarter.

Mr. Volavka compared Pennsylvania's hospital database to the recently unveiled Centers for Medicaid and Medicare site intended to inform consumers about most Pennsylvania hospitals' quality. He said the trouble with CMS's site is its focus on process measures exclusively rather than including outcome measures. Some of the health plans and hospitals with poor ratings have used PHC4 data to improve their outcomes. Aggregate data is used to determine allocation of state healthcare resources. Any time a public report is release, a news release is issued. Newspaper reports on Council findings result in industry pressures and policy shifts.

The National Association of Health Data Organizations (www.nahdo.org) provides direction in what can be done with limited healthcare data. Mr. Volavka said he is a NAHDO Board member and he encouraged Wyoming to join the organization, to gain access to neighboring states' data (Utah) when possible. Wyoming does have access to at least data on state employee and Medicaid recipients. Mr. Volavka said, "With the data you have now, there are incredibly interesting things you can do as public policy makers. If you go to AHRQ (Agency for Healthcare Research and Quality) has available on its web site a number of different types of quality indicators including free download software and if you have billing data you can use these patient safety indicators, run your data against them and start comparing what your subpopulation looks like compared to the nation as a whole. You have the capacity to look at medical errors. They're called misadventures. I think it would be interesting to know how many patients in a Wyoming hospital had a misadventure. You can look at hospital acquired infections. There are lots of things you can do, even with the limited data. I know without ever looking at Wyoming's data that it ain't perfect. It's okay if you start to use it; whoever's submitting it will make it better."

Pennsylvania had certificate of need review in place until 1996. The state has considered reinstating CON. Ambulatory surgery centers have grown over 200 percent. CON legislation has been introduced to limit MRIs and CAT scans. "There has been an explosion of building of hospital facilities. If we had spent one tenth of the money on improving patient safety in the state that we've spent on bricks and mortar, we'd have a heck of a lot more people alive," Mr. Volavka said.

Health care premiums continue to rise in Pennsylvania. The PHC4 data is being used by more organizations to negotiate costs but the data has not been used to the extent that it can be to assure that quality care is achieved at the lowest possible cost, Mr. Volavka said.

Commissioner Jenkins noted that Buffalo's newspaper used the CMS data to question the Johnson County hospital administrator about that hospital's results. Commissioner Bryce

said the Health Reform Commission of the 1990s recommended that a health database be launched and the Legislature was stymied by the need to direct the maintenance and "ownership" of the data into some existing or new government entity. Commissioner Glode said he learned that PHC4 started with a high error rate and refined its work over the course of 20 years to get within a 15 percent error rate. The stakeholders at the table are critical to success, when setting out to chart a similar course, he said. Part of the program has to be assuring that hospitals are filling out reporting forms correctly and coding correctly. "My advice is that we try to do a project like this," said Commissioner Glode. Commissioner Roberts pointed out that AHRQ and CMS are already doing databases, making a Wyoming-specific product palatable to policymakers. Commissioner Mossbrook said the analysis of the data and what is done with it is as critical as how it is collected. "The structures can't just say we'll collect this data and throw it forth. We have to build the structures that say this is what we really think this data says before we take it out anywhere," he said. Chairman Muirhead said, "I think we as a commission have experienced that, with data being out there but no one has analyzed." Commissioner Bryce would like the PHC4 "FYI" documents analyzed to see whether there are any that appear to be immediately applicable to Wyoming.

Kennecott Energy Company's Russell Trinter presented "Initiatives to Address Healthcare Cost."

Benefits, wellness and occupational health are being wedded within Kennecott, to prevent injury and illnesses using global standards in this international company (Kennecott is a subsidiary of Rio Tinto). Although there was a leveling off in 2004, active employees' healthcare costs are increasing and average $8,000 per employee (compared to about $6,000 nationally). The company as 1,800 employees and over 4,000 insured lives (including spouses, dependents and retirees). Total benefits cost $16million to $17 million, most of which is for healthcare. We invest about $500,000 annually in wellness. Projections are for that to increase rapidly. Some of the costs have been passed on to employees. They feel that have been hit hard but a lot remember when everything was covered 100 percent. This is a very sensitive area. We hope to go a couple of years without any change; to them it seems like every year we're coming out and taking something away. The mining industry has exploded globally and there's more demand for mining talent around the world. There has been turnover. Exit interviews do not point to health benefits as being the reason.

A company has been hired to bring in a health advocate to help employees with smoking cessation, weight management and case management in cases of injury (occupational and non-occupational). The program emphasizes prevention and early detection to help employees identify health risks and prevent them to avoid high cost claims. Healthy behavior and relationships with personal physicians are encouraged for employees and spouses. To get incentive money, employees need to get a routine physical with their healthcare provider or complete the annual company sponsored wellness testing, or both. There are wellness team at each mine site and there are company sponsored activities (bike outing in the Black Hills, for example). There are not health promotions at the work

site unless organized by the site (i.e. there have been weight loss competitions with Weight Watchers at the work site to do weigh-ins).

In 2004, a consumer directed health plan was introduced with a healthcare account (HCA). Employees hopefully make good consumer based decisions on how they spend that money. A little under one-third of employees have elected that option. The Company HCA amount ranges from $3,500 to $6,000 with deductibles from $6,000 to $9,500, an out of pocket limit of $5,000 and account maximums (rollover allowed year to year) ranging from $15,000 to $22,500. Blue Cross Blue Shield is the third party administrator for claims (TPA). Debit cards proved to be too difficult but there is an automated card in place that allows employees to access providers across the country. Employees are encouraged to carefully review their medical treatment bills. There's no prescription plan attached to the consumer driven health plan. However, certain preventive and wellness benefits are covered with a $15 co-payment per visit, and routine physical exams and mammograms ordered at part of the exam are not subject to deductibles or co-pays. E-mail contact with physician is incentivized to reduce costs of office visits, Mr. Trinter said. Flexible Spending Accounts (FSA) can help manage health and dependent care expenses while reducing taxes. Separate accounts are offered for employees and qualifying dependents. Benefits administration has been out sourced to Aliquant.

The Campbell County Healthcare Forum was formed when the relationship between the mines and the local hospital was not good; the hospital viewpoint was that no matter what the hospital charged for health care, the mines would pay it. The goal was to bring the parties together. It functioned to bring everybody together but the issues were not addressed until recently. There's a small band that has gone through the growing pains to still function. The group now includes Blue Cross Blue Shield, employer groups, hospital human resources and the CEO, physicians (intermittent involvement), public entities, and the goal is to promote a healthy community, Mr. Trinter said.

The Forum has increased access to local and regional healthcare providers, encouraged appropriate utilization of resources, promoted overall community health, decreased unhealthy habits and realigned community mores', aligned available resources to community needs and educated the public consumers and providers. "We believe consumerism in health care will be a bigger force in the future and we want people to be ready for that," he said. Consumers want engaged professionalism meeting needs with timeliness and accessibility meeting anticipated standards – some are leaving the local providers for competitors' local clinics.

Some of the beliefs of the forum are that healthcare costs, including insurance premiums, will continue to increase. Individuals will continue to assume more of the costs associated with their own health and healthcare. Individuals will act ore like aggressive shoppers and less like complacent users of healthcare services. Population and population demographics will shape the healthcare delivery system, and the healthcare delivery system will continue to develop a greater interdependence between providers and consumers. "I really think we've seen the beginnings of this already with the number of people leaving the area for health care. No one here is trying to destroy the hospital; we

want to work together to make the hospital an efficient and effective source for us." Healthcare providers need to understand the power of consumer demand, efficient management of disease, growing use of benchmarks to judge various aspects of healthcare – from quality to safety to customer service. There are two MRI machines in Campbell County and a lot of MRIs done.

Consumers need to understand their own insurance benefit plans and what they are doing to prevent catastrophic illnesses and injuries. Most healthcare consumers don't understand the terms but are developing a growing knowledge base. There is no one formula for success – it's all about shared successes.

<u>Pennie Hunt, Wyoming Health Resources Network Director, presented her organization's work toward better health in Wyoming.</u>

WHRN was created in 1995 by the Hospital Association, Medical Society, Department of Health and Nurses Association to recruit and retain health care providers in Wyoming. Goals include supporting and enhancing the health care infrastructure and delivery system, operate a clearinghouse on a variety of healthcare issues, advocate for good health practices and inform policy makers and serve as an unbiased forum for policy ideas. WHRN helps the Department of Health facilitate community health grant programs, including the Wyoming Quit Tobacco program, which has been invited to Kennecott to work with its employees. WHRN collects data to recruit but also to support Wyoming organizations by being a repository for healthcare provider information. WHRN started surveying providers in 2004 in response to state need for a quantification of physicians providing medical care in Wyoming.

Snapshot data was not what the state needed. A viable, living database continually updated is what is needed. Individual professionals need to be tracked. Without outside funding, WHRN launched efforts to begin a repository. WHRN's statistics and finance coordinator, Chelsey McManus went from part to full time status to do county by county surveys of facilities, physicians, physician assistants, nurse practitioners and optometric staff. Information is obtained from the Office of Rural Health, Department of Health, Medical Society and Hospital Association, which are all participating in WHRN's database, and practitioners are phoning in updated information. Data is being collected on vacancies at facilities. WHRN is soon going to have Geographic Information System (GIS) mapping integrated into the data repository.

Ms. McManus outlined the different relationships being built to assure collection of data that is accurate and complete for every provider in a county (including name, gender, age, and specialty), the types of services that provider is offering and the locations where the providers are working. Locum tenens (temporary) and telemedicine (remote locations through electronic linkages) physicians and other states' traveling practitioners delivering medical care in Wyoming are also tracked. Platte County was used as an example. The tracking includes determining whether a state or federal loan repayment program or medical education program assisted in furthering a provider's education and their employment in Wyoming. Ten counties are completed, to date. WHRN's future plans for

partnering with ESRI (Environmental Systems Research Institute) for GIS mapping will allow the tracking of physicians and other providers with a computer mapping program.

Discussion followed, led by Commissioner Mossbrook, regarding the software WHRN is using and the survey instrument and the longevity and potential for sustaining the database envisioned. Questions also concerned whether WHRN's initiative or a Nebraska health professional tracking program would be the most viable, effective means of collecting Wyoming data, analyze it and make recommendations with it. Ms. Hunt argued that the money and work should be kept in Wyoming, that surveyors based in Wyoming would have greater success with getting provider participation and that with assistance; WHRN could excel to meet Nebraska's point of service. Commissioner Mossbrook said that Nebraska could help jumpstart the Wyoming effort, and transition control of the database, software and skill sets necessary to maintain it to Wyoming within five years.

Subcommittee updates

<u>Update from Dr. Geoff Smith, IT2, and Michael Rodriguez, JSI re electronic health records study</u>

Today is the last for first round of focus groups throughout the state; 10 communities have been sites for information gathering with community and hospital physicians, pharmacists, hospitals, and ancillary providers. More than 120 people have given feedback on their attitudes for electronic health records systems and willingness to work toward information sharing technology. Following today's focus group in Cody, the data gathered will be compiled. About a third of the participants are physicians, a third are hospital providers and a third are ancillaries.

One opportunity developing is the provision of information and education about what electronic health records are, what information technology is and what the spectrum of uses are. There was some recognition within the hospital system that something like a mandate to move toward a particular system, standard or program would be the only way to get physicians to move. On the other side, we unequivocally heard from the physicians that there would not be acceptance of any kind of a mandate. Solo practitioners are having more trouble seeing where implementing new technology would be of benefit for them. Multi-specialty groups or docs more closely tied to a hospital were more accepting and willing to endorse electronic systems. Where there were systems in place that were not working, like when x-rays did not come back quickly enough, physicians would blame technology. We have spoken with a hospital that made available lab and x-ray results online through a web portal that allowed them to look at the results of their patients within 24 hours. Physicians who didn't get the results back in the time they expected were convinced it was the technology. In reality, there was one radiologist in the community who was overwhelmed and it took time to read, dictate and post his work. Technology got blamed, though. Dr. Smith met with federal officials in Washington, D.C., and learned about efforts nationally to coordinator electronic health records uniformity. The healthcare information technology clearinghouse, www.cchit.org, is

certifying software and talking about national standards for commonality of electronic health records.

A preliminary report will be issued May 2 and public comment sessions will be held in Casper May 3 (see www.wyominghealthcarecommission.org for more information).

Dixie Roberts, Medical Errors Committee

Six years ago, a call for eliminating medical errors was issued nationally. No significant inroads can be claimed. Commissioner Roberts's committee has reviewed over 700 documents. There is some general consensus on the definition of a medical error and adverse event. There are many societies and organizations that have set standards. The last month has been dedicated to the successful implementation of safety systems in hospitals. A hospital willing to do a pilot has been identified. Whatever recommendations the committee makes will not make the state closer to eliminating medical errors than 10 years, but incremental measures to encourage safety and reduce costs can be proposed. Commissioner Glode said the state Legislature chose which set of errors are going to be measured in Wyoming. The standard may change and the statute does not allow for that evolution. He said the electronic health records subcommittee needs to communicate with the medical errors subcommittee to assure that findings are shared.

George Bryce, Purchasing Pools Committee

Health risk assessment and health promotion programs are being implemented by Kennecott, Arch Mineral, school districts, and the state of Wyoming (BE WELL pilot) and there needs to be outreach to the un- and underinsured populations. He reviewed his committee's work to find ways to reduce cost shifting and increase the availability of affordable health care coverage, while simultaneously lowering claims cost. He said other states are doing interesting things – Gov. Mitt Romney has come up with a $200 health care plan in Massachusetts that actually costs $350, so the state is subsidizing the premium, and Healthy New York offers subsidy to companies who have been without coverage for a 12-month period and who agree to buy coverage under a state reinsurance program paying claims above $5,000 (required a legislative decision to put general fund dollars in the pot to pay claims). Both the Massachusetts and New York plans require subsidy.

Wyoming has two reinsurance pools. Lloyd Wilder and Mark Pring of the state Insurance Department have provided research on the high-risk segment of the market covered by the WHIP (Wyoming Health Insurance Pool for those who cannot get coverage from private insurers) and small group pools. WHIP inevitably has high loss ratios applied to it because some members of the pool have claims. A formula has been set up where companies that sell individual and group health insurance get assessed the losses that inevitably happen to this block of business. They get a credit against their premium tax (80 percent). The general fund subsidizes it because less premium tax money is coming in. It works to a degree in that 700 people have health insurance that wouldn't otherwise have it. Premiums are high. If they were lower, some of the healthier uninsured would be

able to get coverage from the WHIP. Idaho takes a percentage of premium tax, applies it to that group of people and subsidizes premiums that bring them down to market level. WHIP is in the process of looking at an HSA option.

The small group market seems to be the most broken, right now. They have a reinsurance mechanism that is called a prospective reinsurance pool. Carriers decide whether they can to cede (give) that risk into the pool and to do that, they have to pay a premium that is currently five times the market rate. The cost is $25,000 per person by the time they pay a premium and their share of the co-insurance. It almost has to be a guaranteed loss deal for someone to be willing to cede an individual into it. If they want to put a whole group in because the group is “sick,” they have to pay one and a half times the standard market premium for that group. It’s almost a shake of the dice – do we want to gamble this group will cost more than the cost of ceding them to the reinsurance pool. There are only 28 people in the small group pool. There are retrospective pools. The school district and large employers have a stop loss (attachment) point at which they reinsure to cover large claims, which is retrospective rather than prospective.

What we’re working on now with Mr. Wilder’s help is working with the people who manage Wyoming’s pool to see whether there is a smarter way for this to be done, and perhaps is already being done in another state, prospectively or retrospectively. Senate File 104 in the last session came up with $7 million paid by all insurance carriers to help fund the losses of a prospective small group pool. Inevitably there will be a conversation with an actual firm that has done this before to look at tying together the WHIP and small group pools. In New York, they say it makes a 25 percent difference to reinsure, but they subsidize 25 percent of their claims with state funds. One of our hardest jobs is going to be determining what the most effective way is to spend money in our whole arena. We are going to spend time trying to figure out evidence based medicine and how it can impact payment of claims.

<u>Steve Mossbrook, Demand Side Committee (for Paul Lang)</u>

The rural health study continues to be refined. It will be released on the Commission’s web site with in a week. It’s not going to be a published study. We have not chosen to go forth with release of the massive quantities of data because we are not confident the work is sufficiently accurate. Earlier this year, we made some larger scope recommendations in terms of where we wanted to go with Supply Side issues. We determined there needed to be smaller, easily-digested pieces that can be explained properly to the Legislature and stepping stones to a longer term change process as opposed to anything that would be sufficiently sudden so as to be disruptive. We don’t want to break the system; we want to change the system over time, advancing toward a goal while producing concrete results. We’ve produced a list of ideas of things we may run with. Those ideas include expansion or initiation of free clinics and PharmAssist, hospital report cards, end of life care, and mental health (aside from addiction) programs. There are 13 issues on the table to continue discussing. In June, a working list of five or six issues will be brought to the Commission to consider and then there will be determination of the resources needed to further study those.

Department of Health Office of Rural Health Manager Lynne Weidel said that her staff is working with national recommendations for report cards for Critical Access Hospitals and asked whether there will be opportunities to work with the Commission on its priorities. Commissioner Glode said one of the goals will be to bring groups together to ask them to join forces with the Commission's objectives and some of that work will be replaced. The Commission is looking for areas where greater effort is required to advance the overall advancement of reform and not fits and starts that overall does not accomplish anything, Commissioner Mossbrook said. Every one of these efforts that we are talking about encompasses something that is presently being done in some measure somewhere in the state. It's not that these are things that everybody forgot to do – these are things that are underway, may not be receiving the energy, the money, the resources, they need to do the best job they could be doing. One of the things we need to figure out is the prioritization of where we think the resources should be applied.

Review of Dr. David Lawrence presentation in Denver 4/15/05 (by Anne Ladd)

Former Kaiser Permanente President Lawrence is a healthcare futurist who presented in Denver. His contention is that delivery system reform must preceed financial and payment reform. His contention is that the existing delivery system is unable to cope with the myriad of forces acting upon it. Among those forces he lists the number of health care technology advancements, aging population, growing population, the threat of pandemics and American's increasing interest in obtaining the latest and greatest healthcare. There are not enough nurses and other healthcare providers and there is no possibility of catching up. Healthcare has done little to invest in its infrastructure; it's basically a cottage industry. It's a fractured mess.

He recommends that health professionals work in care teams, not independently, since for every episode of illness a patient will see six different professionals. Those professionals become adept at specializing in particular health conditions and they see every patient with that health condition. Instead, highest professional skill sets are allocated to more complicated conditions while primary and preventive care is by non-physician healthcare professionals. Immunizations and well child checkups can be done at school-based clinic and by public health professionals. Primary care physicians' time is being wasted on acute, non-life-threatening, self-limited conditions (colds, sprains). The same care could easily be delivered by mid-levels (nurse practitioners, physician assistants). "Value" drivers range from community resource requirements to patient and family values, resource intensity, and scientific scope. Value drivers are used as determinants when organizing a more rational healthcare delivery system. There are tradeoffs between prevention and end of life care, as a limited set of resources are reallocated to make long term gains.

Audience comments

Gerry Kiplinger, APS

APS is working to support Medicaid clients through health management and utilization management contracts. The Commission's objectives overlap with APS's, Mr. Kiplinger said. We have case managers working with people to improve healthcare outcomes and reduce healthcare costs. Mr. Kiplinger distributed information to the Commission about APS's work. He said his company identifies by county and stratifies them at a certain burden of illness. It shows by county the six disease states that APS is working with and the number of clients with those diagnoses by county. A small grant was received from the state to put Health Buddies is Albany, Laramie and Fremont counties. "The push is on right now to get these deployed," he said. The information from the Health Buddies goes directly to the health coach and provides trending to people to provide case management services. There are 25 health coach nurses available to Medicaid clients. An estimated 8,300 people are in need of health coach assistance according to predictive modeling and claims studies APS has done, and 75 percent of them are enrolled in health coach caseloads. Focus is being given to transitioning children back in Wyoming who are presently out of state in placements necessitated by the absence of available local services in Wyoming.

Commissioner Glode said that for cardiac care, the cluster approach is nearing and he believes making the transition soon is possible where there is organization and will. Discussion followed regarding the potential for telemedicine in chronic disease management, public health nurses and school nurses as delivery points for simple medical needs, and urgent care clinics attached to emergency rooms (thereby reducing the healthcare professional shortage crisis). We have to be willing to tie in resources outside of the state, Commissioners Muirhead and Bryce said.

Meeting adjourned, 5:30 p.m.

The next Commission meeting will be May 22-23.